1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04113

4124

Reg. Dist. No. 195

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Howard

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessup

c. LENGTH OF STAY IN 1b: 2 months

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessup

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ~~Home~~ Guilford Road

d. STREET ADDRESS: Guilford Road

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Nancy Middle: Elizabeth Last: Duvall

4. DATE OF DEATH: Month: April Day: 20, 1956 Year: 19

5. SEX: Fem

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: August 8, 1870

9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Elijah S. Riley

14. MOTHER'S MAIDEN NAME: Elizabeth Jarmas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Nettie Brown 818 W.36th St., Balt., Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic C-V-Dis. — 5 yrs.

DUE TO (c): Generalized Arteriosclerosis — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Obliterative Endarteritis legs; Gangrene

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/18, 19 29 to 4/20, 19 56 that I last saw the deceased alive on 4/19, 19 56, and that death occurred at 5:40 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. M. Warren M.D. ADDRESS (Street, city or town, state): 305 Jr. Gro. Laurel DATE SIGNED: 4/22/56

PHYSICIAN'S NAME (Type): J. M. Warren

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 23, 1956

22c. NAME OF CEMETERY OR CREMATORY: Savage Cemetery

22d. LOCATION (City, town, or county) (State): Savage Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: [illegible]

24c. REC'D BY REGISTRAR DATE: 4/22/56

24d. REGISTRAR'S SIGNATURE: Frank Shipley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4125 **CERTIFICATE OF DEATH**

04115

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b: 2days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Shaffer Convalescent Retreat

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 225 9th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: M. — Last: Jones

4. DATE OF DEATH: Month: April — Day: 13 — Year: 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 14, 1913

9. AGE (In years last birthday): 42 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Frostburg, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edward G. Arnold

14. MOTHER'S MAIDEN NAME: Mary Keirs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wm. C. Jones — Address: 225 9th St., Laurel, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	PULMONARY EDEMA, ACUTE	
DUE TO		
(b)	CONGESTIVE HEART FAILURE	10 YRS
DUE TO		
(c)	NEPHRITIS, CHRONIC	10 YRS

592X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ASTHMA, RECURRENT

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT, WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): NONE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): NONE

20c. TIME OF INJURY: Hour a.m. p.m. NONE Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ NONE

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): NONE

20f. (City or town) (County) (State): NONE

21. I certify that I attended the deceased from 1/17 19 56 to 4/13 19 56 that I last saw the deceased alive on 4/12 19 56, and that death occurred at 11:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. L. Erickson M.D. — ADDRESS (Street, city or town, state): Laurel, Maryland — DATE SIGNED: 4/14/56

PHYSICIAN'S NAME (Type): R. L. Erickson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 17, 1956

22c. NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Park

22d. LOCATION (City, town, or county) (State): Frostburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert Conrad Log — ADDRESS: Laurel Md

24a. REC'D BY REGISTRAR DATE: APR 16 1956

24b. REGISTRAR'S SIGNATURE: John Laughran

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04116

4126 CERTIFICATE OF DEATH

Item 7, FilmG196 5-2-56et

Reg. Dist. No. 191

1. PLACE OF DEATH

COUNTY HOWARD — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY

LENGTH OF STAY (in this place) 1 WK.

HOSPITAL OR INSTITUTION OR STREET ADDRESS SHAFFERS NURSING HOME MONTGOMERY ROAD.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND COUNTY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3 V 01-4

STREET ADDRESS (If rural give location) 804 EVESHAM AVE.

3. NAME OF DECEASED (Type or Print) (First) HENRY (Middle) G. (Last) MAYNADIER

4. DATE OF DEATH (Month) April (Day) 25 (Year) 19 56

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE	Single	AUG. 15, 1871	84 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
BANKER	FINANCE	HARFORD Co. MD.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GEORGE YELLOTT	LAURA THOA MOORES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	NONE	COLIN F. MACKENZIE 814 EVESHAM AVE.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X IMMEDIATE CAUSE (A) CEREBRAL THROMBOSIS + SOFTENING — INTERVAL BETWEEN ONSET AND DEATH: 1 mo

ANTECEDENT CAUSE(S) DUE TO (B) CERERRAL ARTERIOSCLEROSIS — 10 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) SENILITY — 10 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 10, 19 55, to Apr 24, 19 56, that I last saw the deceased alive on Apr 30, 19 56, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

SIGNATURE A. S. Chaffant M.D. **ADDRESS** (Street, city, town, state) 6210 York Rd Baltimore 12 **DATE SIGNED** Apr 26 56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	4/28/56	CHRIST CHURCH CEM.	ROCK SPRING FOREST HILL MD.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
APR 30 1956	John B Langhenry	W. Hancock & Sons Co. 4905 York Rd

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04117

4127

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Howard, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cooksville
c. LENGTH OF STAY IN 1b: 35 year
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cooksville
d. STREET ADDRESS: Route #97
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nina Middle: Davis Last: Meadows

4. DATE OF DEATH: Month: April Day: 15 Year: 1956

5. SEX: Female

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 2, 1895

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Public School

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fletcher Meadows

14. MOTHER'S MAIDEN NAME: Josephine Rucker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Miss Cora E. Meadows - Cooksville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest, pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Oct 1954
DUE TO (b): Carcinoma of breast with generalized — April '56
DUE TO (c): Metastases -

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 19 54, to April 19 56, that I last saw the deceased alive on 15 April 1956, and that death occurred at 10:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard E Hall M.D. ADDRESS (Street, city or town, state): Sykesville, Md. DATE SIGNED: 4-16-56

PHYSICIAN'S NAME (Type): HOWARD E. HALL

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/20/56

22c. NAME OF CEMETERY OR ~~CREMATORY~~: River View

22d. LOCATION (City, town, or county) (State): Martins Ferry + Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight ADDRESS: Sykesville Md

24a. REC'D BY REGISTRAR DATE: APR 18 1956

24b. REGISTRAR'S SIGNATURE: A. H. Hesnick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04118

4128

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH
a. COUNTY Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup
c. LENGTH OF STAY IN 1b Emanuel
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup
d. STREET ADDRESS Mission Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Marie — Middle L. — Last Ohler

4. DATE OF DEATH Month April — Day 15 — Year 1956

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH May 23 1866

9. AGE (If years last birthday) 89 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary

10b. KIND OF BUSINESS OR INDUSTRY publishing Co.

11. BIRTHPLACE (State or foreign country) Waterloo Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Adam N. Ohler

14. MOTHER'S MAIDEN NAME Sallie Maria Baldwin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO.

17. INFORMANT Address Mr. Jean M. Urban Jessup, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 3 hr.
DUE TO
(b) Arteriosclerosis
DUE TO
(c)

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-29, 1956, to 4-11, 1956, that I last saw the deceased alive on 4-11, 1956, and that death occurred at 9:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Frank L. Weaver Jr. M.D. — ADDRESS (Street, city or town, state) 320 Montgomery, Laurel, Md — DATE SIGNED

PHYSICIAN'S NAME (Type) FRANK L. WEAVER, JR.

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation — 22b. DATE THEREOF 4/17/56 — 22c. NAME OF CEMETERY OR CREMATORY Mt. Lincoln Cemetery — 22d. LOCATION (City, town, or county) (State) Colmar Manor Md

23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Davidson — ADDRESS Laurel Md

24a. REC'D BY REGISTRAR DATE 4/17/56 — 24b. REGISTRAR'S SIGNATURE Frank Shipley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

4129

04119

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b: 3 mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Highland Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 325 Laurel Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

16-41-2

3. NAME OF DECEASED (Type or print): First Dora — Middle C — Last OWENS

4. DATE OF DEATH: Month April — Day 13 — Year 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 4 1870

9. AGE (In years last birthday) 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Savage Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Walter Owens

14. MOTHER'S MAIDEN NAME: Laura Virginia Haslup

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Mrs. Wm. G. Eccard, 325 Laurel Ave. Laurel, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive CVD — 20yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 1, 1956, to April 13, 1956, that I last saw the deceased alive on April 1, 1956, and that death occurred at 5 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Max J Miller M.D. — ADDRESS (Street, city or town, state): 5226 Balt. Nat. Pike — DATE SIGNED: 4/14/56

PHYSICIAN'S NAME (Type): MAX J MILLER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 15, 1956

22c. NAME OF CEMETERY OR CREMATORY: Savage Cemetery

22d. LOCATION (City, town, or county) (State): Savage, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: DeWitt Davidson Laurel Md

24a. REC'D BY REGISTRAR DATE: APR 18 1956

24b. REGISTRAR'S SIGNATURE: John Langhenry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04120

4130

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b: 8 mos.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Highland Manor Nursing Home

d. STREET ADDRESS: 120 W. Lanvale St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Mary	Small	Reiley		April	17	1956

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	NEVER MARRIED ☒	May 24, 1866	89 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	school teacher	Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Rev. James McKendree Reiley	Margaret Stevenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Mrs. Margaret Stevenson	2733 N. Charles St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vasc. Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

331X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from Aug, 1955, to April, 1956, that I last saw the deceased alive on 4/14, 1956, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thos J Miller MD — M.D. — ADDRESS (Street, city or town, state): 526 Bald Nat Rd — DATE SIGNED: 4/17/56

PHYSICIAN'S NAME (Type): THOS J MILLER M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	April 20, 1956	Green Mount	Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
John O. Mitchell & Sons Inc. 1900 Eutaw Place	APR 20 1956	J. E. Loughran

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04122

4131

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Savage
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Guilford Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Savage
d. STREET ADDRESS: Guilford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MELVIN Middle Jackson Last SCOTT

4. DATE OF DEATH: Month April Day 27 Year 1956

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: September 18, 1866
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): textile worker
10b. KIND OF BUSINESS OR INDUSTRY: cotton mill
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Scott
14. MOTHER'S MAIDEN NAME: ——Norman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Thomas R. Scott, Savage, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Instt.
331 X
DUE TO (b): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/27, 1956, to 4/27, 1956, that I last saw the deceased alive on 4/27, 1956, and that death occurred at 2 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: J. M. Warren M.D. ADDRESS (Street, city or town, state): Laurel DATE SIGNED: 4/27/56
PHYSICIAN'S NAME (Type): J. M. Warren

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: April 30, 1956
22c. NAME OF CEMETERY OR CREMATORY: Savage Cemetery
22d. LOCATION (City, town, or county) (State): Savage, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert Hanaday — ADDRESS: Laurel Md
24a. REC'D BY REGISTRAR DATE: 4/30/56
24b. REGISTRAR'S SIGNATURE: Frank Shipley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04123

4132

CERTIFICATE OF DEATH

Reg. Dist. No. 191

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Within 72 hours after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b: 13 mos
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Taylor Manor Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg
d. STREET ADDRESS: 123 South Oak Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HUGO Middle Last SPELSBERG

4. DATE OF DEATH: Month APRIL Day 20 Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 15, 1894

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR IF UNDER 24 HRS. — Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker

10b. KIND OF BUSINESS OR INDUSTRY: Food Industry

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Spelsberg

14. MOTHER'S MAIDEN NAME: Matilda Czesky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Caroline G. Spelsberg, 123 Oak St. Clarksb erg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Pre-Senile Brain Disease with Psychotic Reaction — 8 years
(c)

305X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9 JAN 56, 19____, to 20 APR 56 19____, that I last saw the deceased alive on 20 APR 56, 19____, and that death occurred at 9:25 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur V. Milholland M.D. — ADDRESS (Street, city or town, state): Taylor Manor Hosp. Ellicott City Md. — DATE SIGNED: 20 APR 56

PHYSICIAN'S NAME (Type): Arthur V. Milholland, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: April 21, 1956

22c. NAME OF CEMETERY OR CREMATORY:

22d. LOCATION (City, town, or county) (State): Clarksburg, W. Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: William J. Tucker & Son Baltimore, Md.

24a. REC'D BY REGISTRAR: April 21, 1956

24b. REGISTRAR'S SIGNATURE: R. W. J. E. Loughran

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04124

Reg. Dist. No. 19 8

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1½ mile S. of Sykesville Rt. 32

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle HOWARD Last UNGLESBEE

4. DATE OF DEATH: Month April Day 24 Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-10-1932

9. AGE (In years last birthday): 23 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Koontz Dairy

11. BIRTHPLACE (State or foreign country): Ellicott City, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William K. Unglesbee

14. MOTHER'S MAIDEN NAME: Ruth E. Bloom

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: W. K. Unglesbee, Sykesville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Compound Comminuted Fracture of Skull — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Multiple Fractures

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto failed to make right curve and struck utility pole

20c. TIME OF INJURY Hour 7.30 p. m. Month, Day, Year 4-24-56 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt. 32

20f. (City or town) Sykesville (County) Howard (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: George E. Burgtorf M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED

EXAMINER'S NAME (Type): George E. Burgtorf — April 24, 1956

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-27-56

22c. NAME OF CEMETERY OR CREMATORY: National Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. C. Higinbothom, Ellicott City, Md.

24a. REC'D BY REGISTRAR DATE 4-27-56

24b. REGISTRAR'S SIGNATURE: Alice H. Hobb

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4134

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04125

Reg. Dist. No. 195

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Savage
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt.1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 30
d. STREET ADDRESS: 929 S.Sharp St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mc KINLEY Middle Last WALLACE

4. DATE OF DEATH: Month April Day 13 Year 19 56

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1905

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Wallace

14. MOTHER'S MAIDEN NAME: Ella Gross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): ?

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Florence Wallace, 929 S.Sharp St. Baltimore 30

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
420.1
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: George E Burgtorf M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4-13-56

EXAMINER'S NAME (Type): George E.Burgtorf

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-17-56

22c. NAME OF CEMETERY OR CREMATORY: Browns

22d. LOCATION (City, town, or county) (State): Calvert County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Marshall P.Hayes, 638 N.Gilmore St, Baltimore, Md.

24a. REC'D BY REGISTRAR DATE: 4/16/56

24b. REGISTRAR'S SIGNATURE: Frank Shipley

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, giving the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Item 4 should be forwarded to the County Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04126 / 193

4135

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Friendship
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Friendship
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First C. Middle ORMAN Last WILCOX

4. DATE OF DEATH: Month APRIL Day 28 Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: SEPT 1883
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Blacksmith
11. BIRTHPLACE (State or foreign country): HOWARD Co. Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: CHARLES WILCOX
14. MOTHER'S MAIDEN NAME: REESE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MARGARET MERSON, Address 3419 KLEINICK Rd, BALTO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shot Gun Wound of Head — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
976X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot Gun wound of Head
20c. TIME OF INJURY: Hour o. m. p. m. ? Month, Day, Year 19
20d. INJURY OCCURRED: While at work [X] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) West Friendship (County) Howard (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and find that death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined cause [X].

ACTUAL SIGNATURE: George E. Burgtorf M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 4-28-56
EXAMINER'S NAME (Type): George E. Burgtorf

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MAY 2, 1956
22c. NAME OF CEMETERY OR CREMATORY: MT VIEW
22d. LOCATION (City, town, or county) (State): ALPHA, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: F. C. HIGH BOTHOM, ELLICOTT CITY Md
ADDRESS
24a. REC'D BY REGISTRAR DATE: 2 May 1956
24b. REGISTRAR'S SIGNATURE: Alice H. Hebb

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04127

4136 **CERTIFICATE OF DEATH**

Reg. Dist. No. 190

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED
COUNTY Howard	MARYLAND	STATE Md. COUNTY Howard
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harwood Park	LENGTH OF STAY (in this place)	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harwood Park
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6910 Highland Rd.		STREET ADDRESS (If rural give location) 6910 Highland Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
LEWIS	MILTON	YOUNG	April 8, 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	married	Jan. 15, 1892	64 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	construction	Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Clark Young	- Fogel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	215-05-0634	Mrs. Anna Young-6910 Highland Ave.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A) Myocardial Infarction

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Coronary Thrombosis DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, ferm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/16, 1954, to 4/8, 1956, that I last saw the deceased alive on 4/5, 1956, and that death occurred at 8:45 P.M, from the causes and on the date stated above.

SIGNATURE	M.D. ADDRESS (Street, city, town, state)	DATE SIGNED
John C. Heagy	Hatchetts Md	4/9/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/11/56	Meadowridge	Elkridge, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
APR 11 1956	E. Bird Hellems	Wm. J. Tickner & Sons-Balto Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4137 **CERTIFICATE OF DEATH** Reg. Dist. No. 04128

1. PLACE OF DEATH:
COUNTY Howard MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge
LENGTH OF STAY (in this place) 2½ mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6435 old wash Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE ~~Md~~ Va COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) South Norfolk
STREET ADDRESS (If rural give location) 701 D St. 83X-3

3. NAME OF DECEASED: (First) George (Middle) Robert (Last) Zimmer
4. DATE OF DEATH: (Month) Apr (Day) 16 (Year) 1956
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) widowed
8. DATE OF BIRTH: Sept 9-1879
9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt (Retired)
10B. KIND OF BUSINESS OR INDUSTRY: F.S. Royster Co
11. BIRTHPLACE (State or foreign country): Baltimore City
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 231-10-0305
17. INFORMANT & ADDRESS: Mrs Austen Zimmer 6435 old wash Rd

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
334X IMMEDIATE CAUSE	(A) apoplexy	4 da
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) General Arteriosclerosis DUE TO	12 yrs
	(C) Arterial Hypertension	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Repeated strokes 5 yrs

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 5, 1956, to Apr 16, 1956, that I last saw the deceased alive on Apr 15, 1956, and that death occurred at 8:30 a M, from the causes and on the date stated above.
SIGNATURE R B Brumbaugh M.D. ADDRESS 1609 main St Elkridge 27 md. DATE SIGNED 4/16/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal
DATE THEREOF 4-16-56
NAME OF CEMETERY OR CREMATORY Indian Ridge Cemetery
LOCATION (City, town, or county) (State) Norfolk, Virginia

DATE REC'D BY LOCAL REGISTRAR April 16, 1956
REGISTRAR'S SIGNATURE C.W. Hedrick
24. FUNERAL DIRECTOR ADDRESS Taylor Funeral Home, Catonsville, Md.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04129

4138

CERTIFICATE OF DEATH

Reg. Dist. No. 191

Howard County

1. PLACE OF DEATH
COUNTY ELLICOTT CITY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTO. MD
LENGTH OF STAY (in this place) 2 WEEKS
HOSPITAL OR INSTITUTION OR STREET ADDRESS HIGHLAND MANOR. N. HOME

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE BALTIMORE COUNTY MD.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SVOL 4
STREET ADDRESS (If rural, give location) CHURCH RD & 6700 HUDSON ST.

3. NAME OF DECEASED (Type or Print) (First) FRANK (Middle) (Last) ZUCHOWSKI

4. DATE OF DEATH (Month) 4 (Day) 18 (Year) 1956

5. SEX M.

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE

8. DATE OF BIRTH 1890

9. AGE last birthday 66 yrs.

If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?

10b. KIND OF BUSINESS OR INDUSTRY ?

11. BIRTHPLACE (State or foreign country) BALTIMOR. MD.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME JOSEPH ZUCHOWSKI

14. MOTHER'S MAIDEN NAME MARY PODLEWSKI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. ?

17. INFORMANT AND ADDRESS MARY GOOD WILL 1104 STEELTON AVE ZONE 24

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause (a) Acute Pulm. Edema — Interval Between Onset and Death: 1 hour

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) due to Arteriosc. Heart Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia — 3 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 14, 1956, to April 18, 1956, that I last saw the deceased alive on 4/14, 1956, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Chas J Reilly MD 5226 Baltimore Rd 4/19/56

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 4-21-1956

NAME OF CEMETERY OR CREMATORY St Stanislaus

LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REG. APR 19 1956

REGISTRAR'S SIGNATURE J. E. Loughenbo

24. FUNERAL DIRECTOR Walter Dabrowski ADDRESS 1001 A. Dundalk Ave.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING